COMMONWEALTH of VIRGINIA

Department for the Aging

Jay W. DeBoer, J.D., Commissioner

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December 7, 2004

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COMMONWEALTH of VIRGINIA
Department for the Aging
Jay W. DeBoer, J.D., Commissioner

MEMORANDUM

TO: Executive Directors
Area Agencies on Aging

FROM: Faye Cates, Human Services Program Coordinator

DATE: December 7, 2004

SUBJECT: MEDICAID'S ROLE FOR WOMEN

Medicaid, the state-federal health coverage program for low –income individuals, provides over 16 million women with basic health and long-term care coverage. The Kaiser Family Foundation has provided an *Issue Brief* that discusses Medicaid's role as a critical safety-net program for the nation's low-income women, and describes the program's role throughout women's lifespans. The brief highlights key benefits of importance to women in their reproductive years, their middle years, for women with disabilities, and for seniors. A copy if the *Issue Brief* us attached.

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ISSUE BRIEF
AN UPDATE ON WOMEN'S HEALTH POLICY
THE HENRY J. KAISER FAMILY FOUNDATION

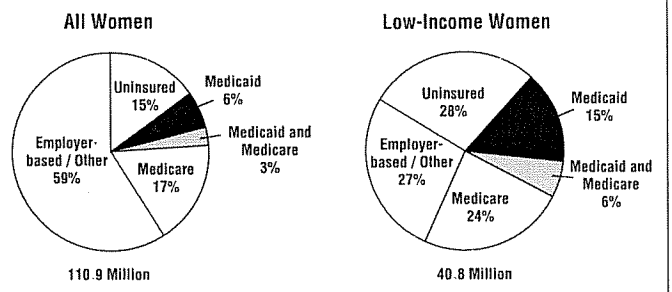
MEDICAID'S ROLE FOR WOMEN

November 2004

Medicaid, the state-federal health coverage program for the low-income population, provides over 16 million low-income women with basic health and long-term care coverage.[1] While often not viewed as a women's health program, Medicaid covers a wide range of health services that are important to women throughout their lives, including reproductive health care, ongoing care for chronic conditions and disabilities, and long-term care.

In 2003, overall, one in ten (9%) women were covered by Medicaid, and among low-income women, one in five (21%) were covered (Figure 1).[2] Women comprise the majority (71%) of adult beneficiaries because they are more likely than men to qualify for the program as the parents of dependent children or with longer life spans to qualify for coverage in their older years.

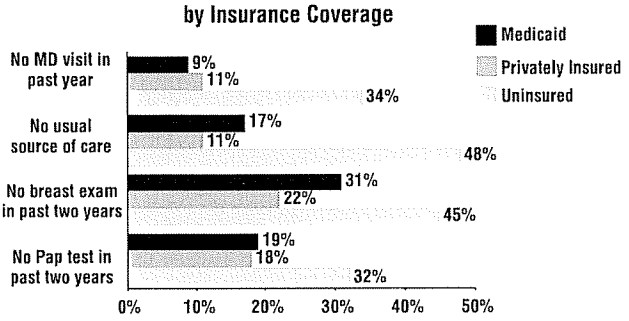
Figure 1
Women's Health Insurance Coverage, 2003



Note: Includes women ages 18 and older.
Low-income defined as family incomes less than 200% of the federal poverty level
Source: KFF analysis of the March 2004 Current Population Survey, Census Bureau.

A large and growing body of evidence has shown that having insurance coverage makes a critical difference in accessing health care, and Medicaid has been shown to improve access for low-income women.[3] Compared to their uninsured counterparts, low-income women on Medicaid experience fewer barriers to care and have utilization rates comparable to women with private coverage (Figure 2).

Figure 2
Access Barriers Experienced by Low-Income Women, by Insurance Coverage

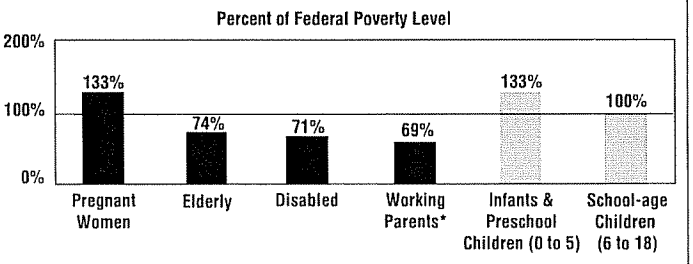


Notes: Includes women ages 18 to 64 with incomes below 200% of poverty.
The federal poverty level was $14,255 for a family of three in 2001.
Source: Henry J. Kaiser Family Foundation, *Kaiser Women's Health Survey*, 2001.

WHO IS ELIGIBLE?

In order to qualify for Medicaid, women must meet both categorical and income criteria. That means that one must fit into a certain "category" such as being pregnant, a mother of a child under 18, 65 or older, or having a disability. Each of these different groups has different income elibiligy criteria, which also vary from state to state (Figure 3).

Figure 3
Medicaid Mandatory Income Eligibility Levels, 2003



*Median eligibility level across all states.
The Federal Poverty Level was $15,260 for a family of three in 2003.
Source: Ross, et al., *Beneath the Surface: Barriers Threaten to Slow Progress on Expanding Health Coverage of Children and Families*, KCMU, 2004.

In most states, the income eligibility levels for adults are at or below the poverty level. Because women are more likely than men to meet these criteria (because they fall into one of the categories and because they are more likely to be low-income), women are more likely to qualify for Medicaid assistance. Many very low-income women, however, do not qualify for Medicaid, no matter how poor they are, because they do not have children under 18 and are not over age 65.

The major Medicaid eligibility categories for adult women are:

Pregnant Women: States must extend eligibility for pregnancy-related services to pregnant women with incomes up to 133% of the federal poverty level (FPL), ($11,944 for an individual in 2003), during the pregnancy and up to 60 days postpartum. States can receive federal matching funds for coverage of pregnant women with incomes up to and beyond 185% FPL. In general, immigrants are banned from Medicaid coverage for the first five years in the U.S., but states can cover women at their own option without federal funds.

Parents with Dependent Children: This group was originally limited to adults who were receiving welfare cash assistance. Today, states can use 1996 welfare income standards to determine eligibility; however, some states have extended coverage to parents beyond these very low thresholds. As of July 2004, income eligibility levels for working parents ranged from 19% FPL in Alabama to 275% FPL in Connecticut.[4]

Seniors and People with Medicare: Low-income Medicare beneficiaries who qualify for Supplemental Security Income (SSI) cash assistance can receive full Medicaid benefits as well as assistance with Medicare cost-sharing. Other low-income seniors who are not poor enough to qualify for SSI can receive some assistance with Medicare cost-sharing and deductibles, but don't have coverage for prescription drugs or long-term care. States can cover people above SSI levels at their own option.

People with Disabilities: Women under age 65 with disabilities who qualify for SSI typically also qualify for Medicaid even if they don't have Medicare.

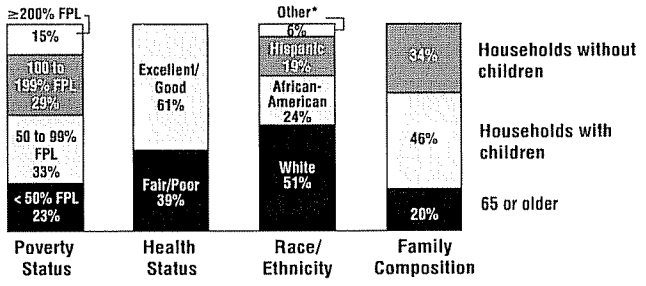
Medically Needy: At state option, eligibility can be extended to others if they "spend down" their assets to meet their state's low income threshold or if their medical expenses are so high that they meet their state's "medically needy" income standard.

Profile of Women Assisted by Medicaid

In 2001, nearly three-quarters (71%) of adults (age 19 and older) on Medicaid were women.[5] This diverse group of women faces many social and economic challenges that affect their ability to receive timely and quality health care. Women with Medicaid are more likely than the total population to be of reproductive age, poor, minorities, less educated, and parents (Figure 4).

- Nearly six in ten (56%) women on Medicaid who live in the community have family incomes below the poverty level. Almost one-quarter (23%) of women have incomes below 50% of the poverty level, about $7,500/ per year.
- Half (46%) of women on Medicaid are living with children in the household.
- Four in ten (39%) women on Medicaid report fair or poor health, three times the rate of women with private coverage or Medicare (13%) or women who are uninsured (12%).

Figure 4
Profile of Women on Medicaid, 2003



Note: Includes noninstitutionalized women ages 18 and older.
*Other consists of 4% Asian/Pacific Islander, 1% American Indian/Aleutian Eskimo, 1% multi-racial. The federal poverty level was $15,260 for a family of three in 2003.
Source: Kaiser Family Foundation analysis of Urban Institute estimates based on March 2004 Current Population Survey, Census Bureau.

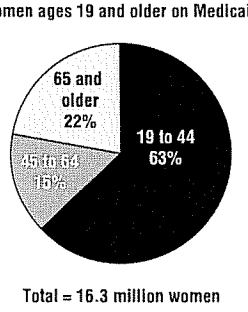
Medicaid and Women's Health Across the Lifespan

Medicaid's benefit package pays for a broad range of services important to women across the different stages of their lives. This includes inpatient and outpatient hospital services, physician services, lab and x-ray services, preventive and screening care, family planning, prenatal care, prescription drugs, and long-term care.

Reproductive Years

Nearly two-thirds (63%) of women on Medicaid are in their reproductive years (19 to 44) (Figure 5). For these women, Medicaid covers a wide range of important services, including family planning, STD testing and treatment, screenings such as pap smears, and pregnancy-related care, (including prenatal services, childbirth, and postpartum care). Medicaid coverage of abortion services, however, is very limited.

Figure 5
Distribution of Women Medicaid Beneficiaries, by Age, 2001

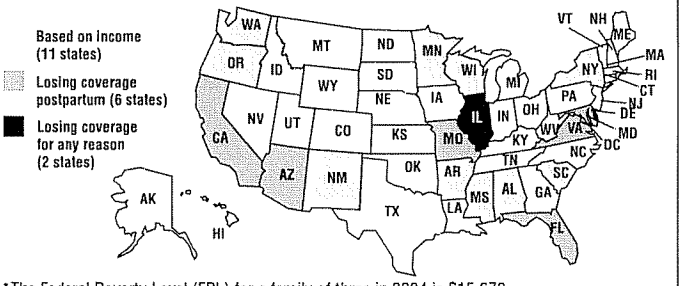


Source: KCMU Analysis of 2001 MSIS Data, 2004.

Family Planning: Recognizing the growing problem of unintended pregnancies in the 1970s, family planning was one of the services explicitly mandated for coverage by federal Medicaid law. To encourage the provision of family planning services, the federal government provides states an enhanced match of 90 cents for every 10 cents they spend on family planning, higher than for other services (typically matched at a rate between 50% and 77%). States can claim this enhanced match for services and supplies that "are expected to achieve a family planning purpose."

- Under this broad guideline, states routinely cover preventive services and screenings such as prescription contraceptives, pap smears, STD testing and treatment, and counseling as part of the family planning benefit.
- Medicaid is the largest source (over half) of public funding for family planning services, reaching $770 million in 2001. Family planning expenditures have kept pace with overall Medicaid spending, rising about 75% between 1995 and 2001, but this is only half the rate of increase for overall Medicaid prescription drug expenditures.[6]
- Family planning services and supplies are exempt from cost-sharing, unlike most other medical services covered by Medicaid. This means women cannot be charged any out-of-pocket costs for these services.
- In recent years, states have developed special Medicaid programs to expand Medicaid coverage for family planning services to women who otherwise do not qualify for the program, including low-income women who are not poor enough to qualify for Medicaid and women who have lost Medicaid coverage. Nineteen states have received permission from the federal government to expand family planning coverage using these programs (Figure 6). In 2001, these programs served 1.7 million women, and recent studies have documented cost savings, reductions in unintended pregnancies, and improved use of family planning services in states with these programs.[7]

Figure 6
Medicaid Family Planning Programs

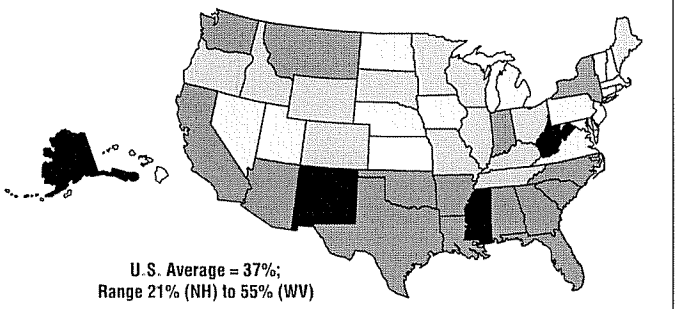


*The Federal Poverty Level (FPL) for a family of three in 2004 is $15,670.
Source: AGI, *State Policies in Brief*.

Prenatal Care and Delivery: Responding to greater attention on rising infant mortality and maternal health, Medicaid eligibility levels were expanded in the late 1980s and 1990s to improve access to prenatal care for low-income pregnant women. Today, Medicaid is one of the largest payers of pregnancy-related services, financing over one-third (37%) of all births in the U.S, and in some states, covering more than half of all births (AK, NM, WV and MS) (Figure 7).

In most states, Medicaid pays for prenatal visits and supplies such as prenatal vitamins, tests such as ultrasound and amniocentesis, and delivery services, including vaginal and cesarean deliveries. Medicaid also covers postpartum care for 60 days, after which the infant is guaranteed coverage for one year, but the mother is not. Coverage for other services, such as nutrition counseling, breastfeeding support, transportation services, smoking cessation, and substance abuse treatment are more limited.[8]

Figure 7
Share of Births Covered by Medicaid, 2000



Note: 100% of the federal poverty level was $14,150 for a family of three in 2000. Data not available for DC, Kansas New Jersey. Data for Colorado and Maine are from 1999.
Source: NGA, *MCH Update 2002: State Health Coverage for Low-Income Pregnant Women, Children, and Parents, 2003.*

Abortion: Medicaid coverage for abortions is very restricted in most states. The federal Hyde Amendment prohibits federal spending on abortions, except in cases of rape, incest, or when the woman's life is in danger. The Amendment does not make an exception for the health of the woman. Seventeen states choose to use only state funds to provide coverage under very limited circumstances for other "medically necessary" abortions.[9]

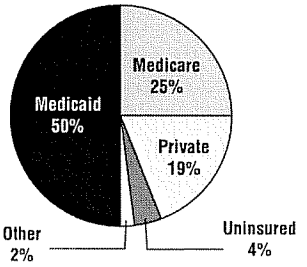
Mid-Life Years

As women age, they experience a higher rate of chronic illnesses and disabilities, and are more likely to report fair or poor health status. Risk for a host of conditions, such as arthritis, hypertension, depression, and diabetes increases with age. Thus, women's health needs shift from reproductive care to greater need for screening and treatment of chronic diseases, mental health care, and disability care (although many women in their reproductive years also have these health needs).

Women with Disabilities: Medicaid plays a critical role financing care for women with disabilities, providing assistance with a broad range of medical and supportive services. These women have severe physical and mental disabilities, including physical impairments, severe mental illnesses, and specific conditions such as muscular dystrophy, cystic fibrosis, and HIV/AIDS.[10] Half of non-elderly women with permanent mental or physical disabilities have Medicaid coverage (Figure 8).

Most people with disabilities on Medicaid qualify because they receive Supplemental Security Income (SSI). These individuals qualify because they are deemed to have a disability that is so severe that they cannot participate in any "substantial gainful activity." Among the benefits that Medicaid covers for women with disabilities are rehabilitation, transportation, and therapeutic services, which help people with disabilities be more self-sufficient and many of which are not covered in private health insurance plans. Long-term care, including home health care is another major health benefit for women with disabilities.

Figure 8
Health Insurance Coverage of Non-Elderly Women with Disabilities, 2003



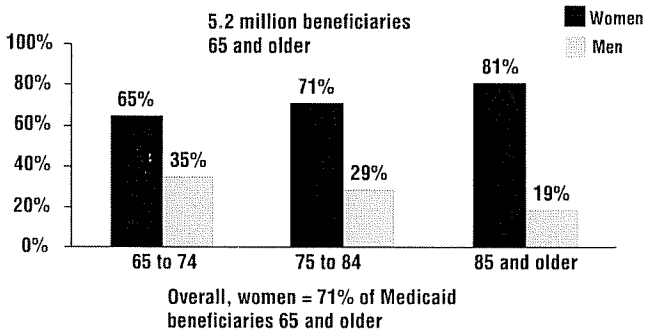
Notes: Includes women ages 18 to 64 with permanent physical or mental disabilities. Does not include women living in institutionalized settings. Medicaid includes women with Medicaid only, Medicaid and private coverage, Medicaid and Medicare. Medicare includes women with Medicare only, Medicare and private.
Source: *Kaiser Disability Survey, 2003.*

Breast and Cervical Cancer Treatment: In 2000, Congress passed a landmark law in Medicaid's history that allowed states to extend Medicaid coverage to uninsured women with breast or cervical cancer. This law built on a CDC program that offered breast and cervical cancer screening services to low-income and uninsured women, but did not extend coverage for treatment to women once they had received a cancer diagnosis. This optional program has been adopted by all the states, although there is considerable variation from state to state in how the program is operated.

Seniors

For over 3 million low-income elderly women, Medicaid pays for their Medicare cost-sharing, prescription drugs, and long-term care services. Only elderly women who are poor or face catastrophic medical costs can qualify. Women comprise the majority (71%) of seniors on Medicaid overall and in every age group because they live longer and are disproportionately poorer than men (Figure 9).

Figure 9
Distribution of Seniors with Medicaid, by Age, 2001



Source: KCMU Analysis of 2001 MSIS Data, 2004.

Medicare Beneficiaries: Medicare beneficiaries who have incomes low enough to qualify for SSI cash assistance are eligible for full Medicaid benefits and are often referred to as "dual eligibles" because they receive both Medicaid and Medicare coverage. Women who qualify as dual eligibles tend to have extensive health needs, face limitations in daily activities, and are very poor. Medicaid currently provides them with coverage for prescription drugs and long-term care services such as nursing home stays and home health care, which Medicare does not currently cover, as well as assistance with Medicare cost-sharing and deductibles.

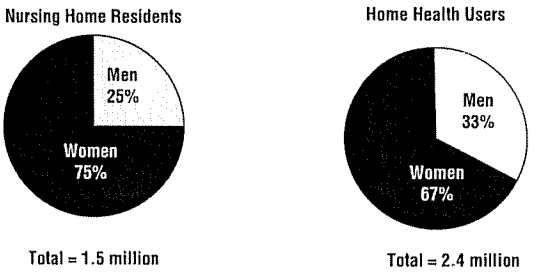
For low-income Medicare beneficiaries whose incomes exceed the SSI threshold (74% of the poverty level), Medicaid's assistance is more limited. Although some states extend coverage to some seniors with incomes up to 100% of poverty, in most states, seniors with incomes between 74% and 120% of the poverty level (known as Qualified Medicare Beneficiaries and Specified Low-Income Medicare Beneficiaries) receive limited Medicaid assistance with Medicare premiums and some of Medicare's cost-sharing requirements. These women do not receive Medicaid coverage for long-term care nor prescription drugs.

Long-term Care: Since women live longer and experience higher rates of chronic illness and disability than men, they are more likely to require long-term care services in their lifetime. Over 70% of nursing home residents and two-thirds of people receiving home health care are women (Figure 10). This care can be extremely costly—a year in a nursing home can cost families $50,000 or more—and have devastating economic consequences for women on fixed incomes.

Medicaid is the major payer of long-term care in the U.S., financing the care of nearly 70% of nursing home residents in the U.S., in part because Medicare does not provide long-term care coverage and there is very little coverage in the private market as well. Because of their health needs, long-term care accounts for the majority of spending on the dual eligibles. Medicaid also covers home- and community-based long-term care services, but coverage for this type of care has been limited.[11]

Prescription Drugs: Many elderly women on Medicaid rely on costly prescription drugs. Currently, there is no or nominal cost-sharing for prescriptions under Medicaid. For dual eligibles, the passage of the Medicare drug benefit may have notable consequences. The law will shift drug coverage for these seniors from Medicaid to the new Medicare Part D program. The new law also has several provisions, including plan-specific formularies, premiums, and cost-sharing that could impede access to needed medications.

Figure 10
Distribution of Nursing Home Residents and Home Health Users, by Gender



Nursing home residents refer to those ages 65 and older.
Source: *Health, United States, 2003*. Nursing home data from the 1999 National Nursing Home Survey. Home Health data from the 2000 National Home and Hospice Care Survey.

Conclusion

Over 16 million women rely on Medicaid to get the health care they need. In the coming years, state and federal officials will be looking closely at Medicaid, exploring options for containing costs in a program that is often the second largest in state budgets. In the past, Medicaid has been used a vehicle to extend coverage to poor and low-income women, mostly mothers, and to provide supports to seniors and people with disabilities who lack resources to purchase the care they need or to fill Medicare's gaps or pay for long-term care. At a time of limited resources, preserving coverage for some of the most vulnerable women in society and addressing the coverage needs of those who are uninsured and outside the reach of the Medicaid's safety net will be among our most difficult challenges.

References

1 Kaiser Commission on Medicaid and the Uninsured (KCMU) analysis of 2001 MSIS data, 2004.
2 Kaiser analysis of Urban Institute estimates of March 2004 Current Population Survey, Bureau of the Census.
3 Institute of Medicine, *Insuring America's Health: Principles and Recommendations,* 2004.
4 Ross, D., Cox, L., *Beneath the Surface: Barriers Threaten to Slow Progress on Expanding Health Coverage of Children and Families,* KCMU, 2004.
5 KCMU analysis of 2001 MSIS data, 2004.
6 Kaiser Family Foundation and The Alan Guttmacher Institute, *Medicaid: A Critical Source of Support for Family Planning in the United States,* April 2004.
7 Frost, et al., "The Availability and Use of Publicly Funded Family Planning Clinics: U.S. Trends, 1994-2001," *Family Planning Perspectives,* October/November 2004.
8 Schwalberg, R., *Medicaid Coverage of Perinatal Services,* Kaiser Family Foundation, 2000.
9 The Alan Guttmacher Institute, *State Policies in Brief,* October 2004.
10 KCMU, *Medicaid Resource Book,* 2002.
11 Ibid.

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COMMONWEALTH of VIRGINIA
Department for the Aging
Jay W. DeBoer, J.D., Commissioner

MEMORANDUM

TO: Executive Directors
Area Agencies on Aging

FROM: Faye Cates, Human Services Program Coordinator

DATE: December 7, 2004

SUBJECT: Virginia Receives *United We Ride* Grant To Explore Coordination Efforts Among Human Service Agencies

Sixty-two federal programs fund transportation for the transportation-disadvantaged. By Executive Order, President Bush has mandated that those agencies providing federally funded human services transportation make every effort to enhance access to transportation to improve mobility, employment opportunities, and access to community services for people who are transportation-disadvantaged. His Executive Order can be found at : **www.whitehouse.gov**. See "News," and click on "Executive Orders," see February 24 item *Human Service Transportation Coordination.*

The Administration would like to see efforts to improve services and achieve cost savings through coordination of transportation activities. The *United We Ride* (UWR) grants via the U. S. Department of Transportation are an effort to support states in their efforts to move the coordination process forward. The Executive Order calls for a significant level of collaboration and coordination regarding access for consumers; regulatory barriers; and cost efficiencies. The federal agencies outlined in the Executive Order have developed an action plan that includes a plan to address concerns and challenges. This action plan includes significant collaboration with stakeholders at the state and local levels.

The Virginia Department of Rail and Public Transportation (DRPT) has received a $35,000 UWR State Coordination Grant, which targets the implementation of the President's Executive Order. The agencies and stakeholders involved in this grant initiative are as follows:

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E-mail: aging@vda.virginia.gov • Web Site: www.vda.virginia.gov

VA Disability Commission (staffed by attorneys from VA Legislative Services)
Secretary of Health and Human Resources
- Department for the Aging
- Department for the Blind and Vision Impaired
- Department of Medical Assistance Services
- Department of Mental Health, Mental Retardation and Substance Abuse Services
- Department of Rehabilitative Services
- Department of Social Services
- Virginia Board for People with Disabilities

Secretary of Transportation
- Department of Rail and Public Transportation

The grant will be used to establish a clear and objective baseline of the Commonwealth's human service transportation resources and unmet needs. Virginia's UWR proposal is focused on conducting a mandated, accurate and complete inventory of the state's human service transportation system. DRPT will prepare an electronic survey for this purpose and to identify barrier, challenges and strategies related to coordination efforts.

Aging will play a key role in the survey effort. DRPT staff will met at VDA December 13, 2004, at 9:00 a.m., for preliminary discussion of aging issues to be covered in the survey. Deputy Commissioner of Programs Bill Peterson and I will meet with Neil Sherman, DRPT Specialized Program Manager. We invite AAA directors and/or transportation managers to be a part of this meeting to share your insights and to identify issues you would like addressed in the survey. Please contact me if you plan to attend. If you are unable to attend the meeting, please e-mail me any comments you have about coordination barriers, challenges at faye.cates@vda.virginia.gov.

For you information, I have attached the DRPT proposal for your review, so your will see the scope of the effort of the grant initiative. See page 4 for information to be obtained via the survey, which your transportation manager can begin to gather. Another reference I'll share with you as an attachment is the *Results in Brief* of the GAO Report 03-697, *Transportation-Disadvantaged Populations: Some Coordination Efforts Among Programs Providing Transportation Services, But Obstacles Persist.*

COMMONWEALTH OF VIRGINIA

UNITED WE RIDE PROPOSAL

The Commonwealth of Virginia has long been committed to interagency communication and collaboration regarding transportation for Virginians with disabilities. The Specialized Transportation Council was formed in the code of VA in 1990, which mandated cross agency and stakeholder collaboration chaired by the Lt. Governor and the Secretary of Transportation. In 2003, to streamline committees within the state, the General Assembly reinforced the need for interagency coordination on transportation for people with disabilities but placed these responsibilities under the State's Disability Commission, a legislative commission chaired by the Lt Governor. Given the request from FTA for each state to identify a collaboration council following the Region III conference on Coordination in June 2003, the Virginia state agencies representing the Secretariat of Health and Human Resources, the Secretariat of Transportation and the Disability Commission determined to combine and coordinate respective efforts together to best address transportation issues in VA in the disability arena. This council will serve as the primary forum where the transportation needs and issues of people with disabilities can be addressed through the joint cooperation of key agencies of the Executive branch, legislature, the Lieutenant Governor, and the Governor's appointees.

The agencies and stakeholders involved in this process are the following:

VA Disability Commission (staffed by attorneys from VA Legislative Services)

Secretary of Health and Human Resources

- Department for the Aging
- Department for the Blind and Vision Impaired
- Department of Medical Assistance Services
- Department of Mental Health, Mental Retardation and Substance Abuse Services
- Department of Rehabilitative Services

- Department of Social Services
- Virginia Board for People with Disabilities

Secretary of Transportation

- Department of Rail and Public Transportation

The Commonwealth of Virginia, through the collaborative efforts of this Council, is now stands ready to apply for a UNITED WE RIDE (UWR) grant. The Department of Rail and Public Transportation (DRPT) has been designated as the lead agency. The contact person for the grant will be the following:

Neil I. Sherman, Specialized Program Manager
1313 East Main Street, Richmond Virginia 23219
(804) 786-14154
Neil.sherman@drpt.virginia.gov

Virginia's Mission

It is the Commonwealth's purpose to empower elderly persons, persons with disabilities and low-income persons to maintain their independence and full participation in the community. This mission has been underscored carefully in VA's Olmstead Action Plan. Affordable mobility, which provides access to essential community services, is key to supporting this state policy. Affordable mobility is critical for many elderly persons, persons with disabilities and low-income persons to access health care, employment, retail, recreation and social engagements and to become more self-sufficient in their lives within the community.

The Council's primary goal is to develop Virginia's Action Plan for Coordinating Human Service Transportation as we begin this new millennium. Based upon the dearth of accurate information on Virginia's intense human community service needs in transportation, the VA Interagency Transportation Council determined that Virginia's UWR proposal must first establish a clear and objective baseline of the Commonwealth's human service transportation

resources and unmet needs. The Council, therefore, determined that Virginia's UWR proposal should be focused on conducting a mandated, accurate and complete inventory of the state's human service transportation system. .

Virginia's Comprehensive UWR Framework for Action

Virginia's Human Service Transportation Inventory proposal will assist Virginia in the future in developing Virginia's Action Plan for Coordinating Human Service Transportation, which will make the most efficient and effective use of limited resources possible based on accurate, complete, and current data, not supposition or guesswork.

Level of Coordination

To ensure collection of the most useful data, DRPT will consult with other states with coordinated systems, such as Florida, Georgia and North Carolina before embarking on this project. DRPT, with its collaborative partners Virginia State Agency Human Services Transportation Committee (Member agencies listed above), will then develop a draft inventory. To ensure that all survey questions are contextually congruent and culturally relevant, this draft will be shared with state and local agencies, transportation providers, and consumers of services in focus groups, VA Olmstead teams and email stakeholder listservs. DRPT will modify and improve the inventory questions based on the stakeholder reviews.

The Secretariat of Health and Human Resources, the Secretariat of Transportation and the Disability Commission will review the inventory and **require** that the survey be completed by all public transportation operators, private for profit operators and private non-profit operators and human service programs throughout the Commonwealth of VA. These operators receive funding in Virginia to transport elderly persons, persons with disabilities and low-income persons and their continued funding will be contingent of appropriate completion of the survey.

Project Description

The Committee though the stakeholder-involved action research process discussed above will finalize the VA Human Service Transportation Inventory. Careful attention will be given to the wording of each item for simplicity, reading level, and applicability across cultures. Researchers will pilot test the survey drafts. The instructions will be given on how to answer each question and algorithms for all questions on determining costs.

All state agencies will notify their transportation provider network of their responsibility to complete the survey. The survey will be submitted on-line over the Internet. The following information will be requested.

Vehicle Inventory

- Number of vehicles by mode (cars, minivans, wheelchair vans);
- Seating capacity of each vehicle;
- Age, manufacturer and model, mileage and condition of each vehicle;
- Ownership status – (leased or owned);
- Accessibility status – (lift, ramp, number of wheelchair position); and
- Communications equipment (radio etc).

Vehicle Utilization

- Hours of use
- Days of use
- Geographic area served (origins/destinations/routes)

Ridership

- Eligibility Criteria
- Number of annual passengers, service hours, and service miles
- Type of service provided (demand response, subscription, fixed route)

Transportation Cost and Revenue Data

- Vehicle operating costs
- Funding sources and amounts

Collaboration Tools

- Software used when sharing vehicles (currently used or wish list)
- Collaborative Billing models (currently used or wish list)

- Ground rules/ Protocols when collaborating (currently used or wish list)

Survey Results and Use

VA Human Service Transportation Inventory is expected to yield the following critical information at the city and county level, which can be made available from the survey to complete the state human services transportation plan and will help the committee begin the strategic VA Collaborated Transportation Action Plan for the next decade:

1. The existence of idle vehicles of excess down time;
2. The availability of unused capacity on vehicles being operated;
3. The potential for current transportation providers to purchase service from a coordinated system at a lower rate;
4. Unmet agency transportation needs; and
5. Tools for collaboration.
6. Consumer Information – The Commonwealth will create an information system to show the availability of human service transportation systems

Consumer Involvement and Outcomes

In addition to the involvement of consumers in forming the questions of the inventory, the results of the Virginia's Human Services Transportation Inventory will be aggregated and reported resource information for consumers regarding services available. Through a public comment process consumers will report to the state what type of services are still needed.

Budget

Development of Inventory Survey on Line	$25,000
Analyze and Present Information	$10,000
TOTAL	$35,000

United States General Accounting Office

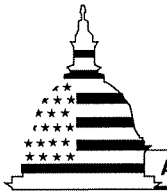
GAO

Report to Congressional Requesters

June 2003

TRANSPORTATION-DISADVANTAGED POPULATIONS

Some Coordination Efforts Among Programs Providing Transportation Services, but Obstacles Persist



G A O

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GAO-03-697

June 2003

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Highlights

Highlights of GAO-03-697, a report to congressional requesters

TRANSPORTATION-DISADVANTAGED POPULATIONS

Some Coordination Efforts Among Programs Providing Transportation Services, but Obstacles Persist

Why GAO Did This Study

Millions of Americans are unable to provide their own transportation—or even use public transportation—for Medicaid appointments, Head Start classes, job training, or other services. Such "transportation-disadvantaged" persons are often disabled, elderly, or low income. Various federal programs are authorized to provide transportation services to them. GAO was asked to (1) identify the federal programs that fund such transportation services and the amount spent on them, (2) assess the extent of coordination among the various programs, and (3) identify any obstacles to coordination and potential ways to overcome such obstacles.

What GAO Recommends

GAO recommends that the Departments of Labor and Education join the Coordinating Council on Access and Mobility. GAO also recommends that the Departments of Health and Human Services, Labor, Education, and Transportation (1) strengthen the Coordinating Council's strategic plan, (2) include long-term goals and measures for coordination in their agencies' strategic and annual performance plans, and (3) develop and distribute additional guidance and information to encourage coordination.

The Departments of Health and Human Services, Labor, Education, and Transportation generally concurred with the findings and recommendations in this report.

www.gao.gov/cgi-bin/getrpt?GAO-03-697.

To view the full product, including the scope and methodology, click on the link above. For more information, contact. Katherine Siggerud at (202) 512-2834.

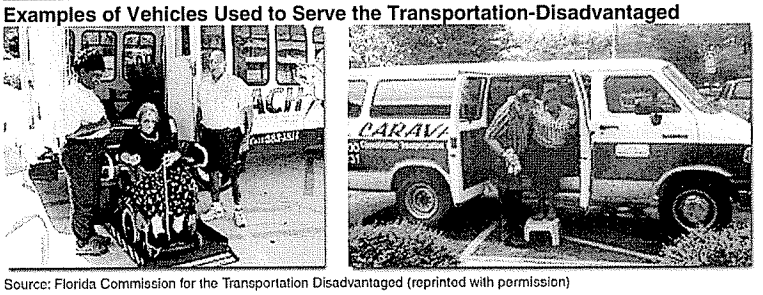
What GAO Found

Sixty-two federal programs—most of which are administered by the Departments of Health and Human Services, Labor, Education, and Transportation—fund transportation services for the transportation-disadvantaged. The full amount these programs spend on transportation is unknown because transportation is not always tracked separately from other spending. However, available information (i.e., estimated or actual outlays or obligations) on 29 of the programs shows that federal agencies spent at least an estimated $2.4 billion on these services in fiscal year 2001. Additional spending by states and localities is also not fully known but is at least in the hundreds of millions of dollars.

Efforts to improve services and achieve cost savings through coordination of transportation activities (through sharing resources or information or consolidating services under a single agency) among federal agencies vary. The Coordinating Council on Access and Mobility—a body with representation from the Departments of Transportation and Health and Human Services—has undertaken some activities to improve coordination. However, other agencies that administer a substantial number of programs for the transportation-disadvantaged, such as the Departments of Labor and Education, are not part of the Council. In addition, the Coordinating Council's strategic plan is not linked to its action plan and contains few measurable performance goals. The strategic and annual performance plans of the Departments of Transportation and Health and Human Services contain few references to coordination relating to their subagencies and programs that fund transportation services for the transportation-disadvantaged, and the plans of the Departments of Labor and Education do not mention coordinating these services.

Obstacles impeding coordination include concern among administrators that their own participants might be negatively affected, program rules that limit use by others, and limited guidance and information on coordination. To mitigate these obstacles, officials and experts suggested making federal standards more consistent, creating a clearinghouse or better Web site to facilitate interagency communication and provide better guidance on coordination, and providing financial incentives or instituting mandates to coordinate.

Examples of Vehicles Used to Serve the Transportation-Disadvantaged



Source: Florida Commission for the Transportation Disadvantaged (reprinted with permission)

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United States General Accounting Office
Washington, DC 20548

June 30, 2003

The Honorable Don Young
Chairman
The Honorable James L. Oberstar
Ranking Democratic Member
Committee on Transportation and Infrastructure
House of Representatives

The Honorable Thomas E. Petri
Chairman
The Honorable William O. Lipinski
Ranking Democratic Member
Subcommittee on Highways, Transit, and Pipelines
Committee on Transportation and Infrastructure
House of Representatives

The ability to access personal or public transportation is fundamental for people to connect with employment opportunities, health and medical services, educational services, and the community at large. However, certain populations in the United States lack the ability to provide their own transportation or have difficulty accessing whatever conventional public transportation may be available. These "transportation-disadvantaged" persons may have an age-related condition, a disability, or income constraints. This is potentially a sizeable group. For example, according to the 2000 U.S. Census, 35.1 million people were over age 65, 44.5 million people were over age 21 and disabled, and 33.9 million people were living below the poverty line. Many within these populations face significant problems in accessing transportation.

Many federal programs authorize use of funds to provide transportation for transportation-disadvantaged people so they can access government programs. Programs that provide incidental transportation include health and medical programs, job-training programs, or programs for the aging. The coordination of these transportation services—through pooling resources, consolidating trips provided by various agencies under a single agency, or sharing information between programs—has been found to improve the quality and cost-effectiveness of service. At the federal level, the Coordinating Council on Access and Mobility—a body consisting of representatives from the Departments of Health and Human Services and Transportation—is charged with coordinating transportation services provided by federal programs and promoting the maximum feasible

coordination at the state and local levels. In a 1999 report,[1] we found that these coordination efforts needed strengthening. We have also issued other reports raising concerns about service coordination.[2]

You asked that we study the extent to which government agencies and programs are currently providing transportation services to the transportation-disadvantaged and coordinating the provision of these transportation services and that we update you on actions taken by the Coordinating Council since our 1999 report. This report addresses (1) the federal programs that provide transportation services for transportation-disadvantaged populations and the types of services they provide; (2) federal, state, and local government spending for transportation services through these federal programs;[3] (3) the extent of coordination among state, local, and federal agencies in delivering transportation services for the transportation-disadvantaged, including actions taken by the Coordinating Council; and (4) any obstacles that may impede effective coordination and potential options for overcoming such obstacles.

Our overall approach was to (1) review federal laws and regulations governing the use of federal funds for services for transportation-disadvantaged populations; (2) analyze spending data where available; (3) review federal and other governmental activities and the research literature related to the coordination of transportation services; and (4) obtain the views of more than 100 officials from federal, state, and local government agencies, industry and client advocacy groups, and other experts involved with or affected by the coordination process on the obstacles and options for improving coordination. Many of these interviews were part of case studies that we conducted in five states—Arizona, Florida, New York, South Dakota, and Wisconsin—to understand how these various federal programs were implemented and coordinated at the state and local level. We chose these states to include a cross section

[1]U.S. General Accounting Office, *Transportation Coordination: Benefits and Barriers Exist, and Planning Efforts Progress Slowly*, GAO/RCED-00-1 (Washington, D.C.: Oct. 22, 1999).

[2]U.S. General Accounting Office, *Welfare Reform: Job Access Program Improves Local Service Coordination, but Evaluation Should Be Completed*, GAO-03-204 (Washington, D.C.: Dec. 6, 2002); *Hindrances to Coordinating Transportation of People Participating in Federally Funded Grant Programs: Volume I*, GAO/RCED-77-119 (Washington, D.C.: Oct. 17, 1977).

[3]For the purposes of this report, spending refers to estimated or actual outlays or obligations, depending on what information was available from the agency.

of characteristics including urban/rural mix, geographic area of the country, and presence or absence of a state council or other coordinating body. Appendix I contains more information about our scope and methodology.

Results in Brief

We identified 62 federal programs—most of which are administered by the Departments of Health and Human Services, Labor, Education, and Transportation—that are used to fund transportation services for transportation-disadvantaged populations. Sixteen of these seem particularly relevant in that the Community Transportation Association of America[4] identified them as being regularly used to fund transportation services. In addition, based on available information, we identified 11 other programs that are notable, in that transportation spending under each one was at least $4 million in fiscal year 2001. While the remaining programs also fund transportation services, they do so minimally, or the extent of transportation services funded is unknown, according to program officials. Most programs purchase transportation services from existing private or public providers. For example, several programs in the Department of Labor typically provide bus tokens, and Medicaid providers often contract with local transportation providers.[5] In contrast, Department of Transportation programs and several others such as Head Start in the Department of Health and Human Services typically purchase and operate vehicles or modify them for use by individuals with disabilities. Several of these 62 programs are required to coordinate services they provide with other agencies providing similar services, which can include transportation.

Federal, state, and local spending for these transportation services is in the billions of dollars, although the full extent of spending is unknown because transportation spending is not always tracked separately from other program spending. In the 29 programs for which we could obtain actual spending amounts or estimates from program officials, federal

[4]The Community Transportation Association of America is a national, professional membership association that conducts research and provides technical assistance for community transportation providers. See Community Transportation Association of America, *Building Mobility Partnerships: Opportunities for Federal Investment* (Washington, D.C.: March 2002).

[5]Medicaid is a joint federal-state program to finance health care coverage for certain categories of low-income individuals, including families with children, persons with disabilities, and elderly individuals.

spending on transportation services for transportation-disadvantaged populations was at least $2.4 billion in fiscal year 2001. Department of Health and Human Services programs spent about three-quarters of this amount. State and local agencies also provide funding for many of these programs, often to fulfill matching requirements, which generally range from 5 to 50 percent of total program costs for these programs. Estimates of state and local spending are generally not available because few agencies track such information at the federal or state level. However, based on available information, it is evident that state and local contributions for these services are significant—at least several hundred million dollars.

Efforts to improve services and achieve cost savings through coordination of transportation activities among agencies at all levels of government vary; however, in some areas we visited, close coordination among providers has shown promising results. Some local agencies have realized substantial benefits by coordinating their transportation services through sharing vehicles, consolidating services under a single agency, or sharing information about available services. For example, a transit agency in South Dakota consolidated the transportation services previously provided by both senior and medical centers as well as other federal, state, and local programs. This consolidation allowed the agency to expand its service hours and increase the number of trips provided while reducing the average cost of providing each trip by about 20 percent. We found instances, however, in which there were overlapping, fragmented, or confusing services among programs that did not coordinate. For example, a local official said that the vans delivering clients to the local job center are owned by many different programs, but because the programs do not coordinate, only a few people ride in each van. At the federal level, agencies have taken some limited steps to coordinate their transportation programs since our 1999 report.[6] For example, the Coordinating Council on Access and Mobility has finalized a strategic plan and issued guidelines for coordinating transportation services. However, the long-term goals and objectives in its strategic plan are generally not measurable, and they are not linked to the activities in the Council's action plan. Also, the strategic and annual performance plans of the Departments of Transportation and Health and Human Services contain few references to coordination of programs for the transportation-disadvantaged, and the plans of the Departments of Labor, Education, and the other federal agencies contain

[6]GAO/RCED-00-1.

no such references. In addition, the Coordinating Council only includes officials from two federal departments (Transportation and Health and Human Services), representing less than half of the 62 federal programs that can be used to fund services for the transportation-disadvantaged, while the Departments of Labor and Education, which administer one-third of the programs, are not members of the Council. Furthermore, while the Coordinating Council is working to improve its Web site, the site is not linked to the Web site of the Department of Health and Human Services, making it more difficult for human service agencies at all government levels to be aware of and access the site.

Although decision makers face numerous obstacles in trying to coordinate transportation services for the transportation-disadvantaged, officials and experts that we consulted also offered several potential options to mitigate these obstacles and enhance coordination among federal, state, and local agencies. We grouped the obstacles into three categories: (1) reluctance to share vehicles and fund coordination activities due to concerns about possible adverse effects on clients; (2) different eligibility requirements, safety standards, and other programmatic requirements that can limit programs' ability to share transportation resources; and (3) lack of leadership and commitment to coordinate, as evidenced by the limited guidance and information provided by federal and state agencies on the possible techniques for coordinating services. To mitigate these obstacles, officials and experts suggested three potential options. One option is to harmonize standards among federal programs—such as safety standards related to types of seat belts and driver training requirements—so that programs can serve additional populations or better share transportation resources. Another option is to expand interagency forums that would facilitate communication among agencies involved in coordination efforts and to share additional technical guidance and information on coordination among federal and state agencies through a central clearinghouse or improved Web site. The third option is to provide financial incentives or mandates that would give priority in federal funding to those grant applicants that show a strong commitment to coordinate or require specific coordination efforts among grant recipients as a condition of receiving federal funding. We did not assess the costs and benefits of these options; however, some would require extensive statutory or regulatory changes and could cause agencies to incur significant costs.

Given the multiplicity of federal programs that can fund transportation services for the transportation-disadvantaged, and the significant amounts spent on those services, effective coordination efforts are needed to ensure that transportation services reach the greatest number of

recipients. Accordingly, our report contains several recommendations designed to strengthen and enhance coordination activities in the four federal departments that administer most of the programs that fund transportation services—Health and Human Services, Labor, Education, and Transportation. In commenting on the draft of this report, those four departments generally concurred with the findings and recommendations. In addition, we provided the draft report to two other departments that provide services to the transportation-disadvantaged—Housing and Urban Development and Veterans Affairs—and those departments also agreed with the findings. In some cases, these departments also provided technical clarifications, which were incorporated as appropriate to ensure accuracy.

Background

Many elderly, disabled, and low-income individuals face significant challenges in accessing transportation. For example, some of these challenges are as follows:

- Sixteen percent of respondents over age 75 reported not having a driver's license in 2001, and 25 percent of the respondents had not driven at least once in the last month according to an AARP survey.[7] Elderly people are also more likely to have difficulty accessing traditional public transportation due to physical ailments.
- Thirty percent of respondents with disabilities reported difficulty in accessing transportation, compared to 10 percent of respondents without a disability, according to a 2000 survey by the National Organization on Disabilities.
- Low-income households are less likely to own a car than other households due to the prohibitive cost of purchasing, insuring, and maintaining a car, and public transportation may not provide sufficient options for their needs. Over 90 percent of public assistance recipients do not own a car.[8]

[7]Anita Stowell Ritter, Audrey Straight, Ed Evans, *Understanding Senior Transportation: Report and Analysis of a Survey of Consumers Age 50+* (Washington, D.C.: AARP Public Policy Institute, 2002).

[8]U.S. Federal Highway Administration and U.S. Federal Transit Administration, *2002 Status of the Nation's Highways, Bridges, and Transit: Conditions and Performance* (Washington, D.C.: Department of Transportation, 2003).

The importance of coordinating transportation services for transportation-disadvantaged populations has been evident since the 1970s. In 1977, we issued a report on transportation coordination,[9] which concluded that the most significant hindrance to the coordination of transportation services under these programs was confusion at all levels of government as to how much coordination federally funded projects could engage in. Since 1986, responsibility for coordinating transportation programs at the federal level has rested in the Coordinating Council on Access and Mobility, which was created under a memorandum of understanding between the Department of Health and Human Services (HHS) and the Department of Transportation (DOT). This body is composed of representatives from program offices within these departments, and employees of the two departments meet its staffing needs, on a part-time basis.

More recent reviews have continued to identify a need for stronger efforts in this area. In a 1999 report on transportation coordination,[10] we found that coordination efforts of the Coordinating Council, DOT, and HHS were ongoing but still needed strengthening. This report also noted that the Congress had endorsed increased coordination as evidenced by several provisions in the Transportation Equity Act for the 21st Century (TEA-21),[11] and significant financial benefits had been realized through coordination. In addition, reports by advocacy groups and transportation researchers have raised concerns over continuing duplication of effort among federal programs and certain sub-populations still not being served effectively.[12]

[9]GAO/RCED-77-119.

[10]GAO/RCED-00-1.

[11]P.L. 105-178.

[12]For example, a report prepared for AARP found that transportation resources for the elderly, disabled, and other groups were often not coordinated, leading to duplication of services. The services were also found to vary in quality and to fail to address the needs of individuals who did not meet specific agency or program eligibility requirements. See Jon E. Burkhardt, *Coordinated Transportation Systems* (Washington, D.C.: AARP, September 2000).

Sixty-Two Federal Programs Fund Transportation Services to Transportation-Disadvantaged Populations

We identified 62 federal programs that fund transportation services to populations that are transportation-disadvantaged.[13] As shown in figure 1, the bulk of these programs are administered by four federal agencies—23 programs in HHS, 15 programs in the Department of Labor (DOL), 8 programs in the Department of Education, and 6 programs in DOT.[14] The remaining 10 programs are administered by the Departments of Housing and Urban Development (HUD), Veterans Affairs (VA), Agriculture, and the Interior. A full listing of programs, their authorizing legislation, typical uses, types of trips provided, target populations, and spending information is found in appendix II.

[13]In addition to these 62 programs, it is likely that there other federal programs that could be used to fund transportation improvements or other transportation services. Our scope included programs that provide nonemergency, nonmilitary, surface transportation services, targeted to transportation-disadvantaged populations. We excluded most programs that were strictly for research or demonstration activities or provided strictly cash assistance with no restrictions on use, as well as some economic development programs that benefit the general public and are not targeted to transportation-disadvantaged populations. Efforts by other researchers to inventory all federal programs that could conceivably provide transportation yielded additional programs not found in our inventory due to differing selection criteria. See *Building Mobility Partnerships: Opportunities for Federal Investment.*

[14]Two DOT programs that are included here, the Urbanized Area and Nonurbanized Area Formula Programs, are used to support mass transit intended for the general public, many of whom could conceivably provide their own transportation. We include them because the Americans with Disabilities Act (ADA) of 1990 (42 U.S.C. 126) requires that transit operators provide accessible paratransit service that is comparable to their regular service for disabled individuals who are unable to provide their own transportation or access the regular transit system, and TEA-21 allows a portion of these transit formula grants to be used to offset paratransit operating costs.